



**STATE OF TENNESSEE**

**DEPARTMENT OF COMMERCE AND INSURANCE**

**TENNCARE DIVISION**

and

**THE OFFICE OF THE COMPTROLLER OF THE TREASURY**

**DIVISION OF STATE AUDIT**

**MARKET CONDUCT EXAMINATION**

and

**LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION**

**OF**

**WINDSOR HEALTH PLAN OF TN, INC.**  
(formerly known as Victory Health Plan, Inc.)

**NASHVILLE, TENNESSEE**

**FOR THE PERIOD JANUARY 1, 2004  
THROUGH JUNE 30, 2004**

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DATE: May 15, 2006

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Windsor Health Plan of TN, Inc. (formerly known as Victory Health Plan, Inc.) Nashville, Tennessee, for the period January 1 through June 30, 2004, was completed November 2, 2004. The report of this examination is herein respectfully submitted.

## **I. FOREWORD**

This report reflects the results of a market conduct examination “by test” of the claims processing system of Windsor Health Plan of TN, Inc. (WHP). Further, this report reflects the results of a limited scope examination of the financial statement account balances as reported by WHP. This report also reflects the results of a compliance examination of WHP’s policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

## **II. PURPOSE AND SCOPE**

### **A. Authority**

This examination of WHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and WHP, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

WHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

### **B. Areas Examined and Period Covered**

The market conduct examination focused on the claims processing functions and performance of WHP. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by WHP on its National Association of Insurance Commissioners (NAIC) statement for the six months ended June 30, 2004, and the Medical Fund Target Report filed by WHP as of June 30, 2004.

The limited scope compliance examination focused on WHP’s provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by WHP before and during the onsite examination, at the Brentwood, Tennessee, office from September 20 through October 4, 2004, and the Tulsa, Oklahoma, office of Perot Systems on November 2, 2004.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that WHP's TennCare operations were administered in accordance with the CRA, and state statutes and regulations concerning HMO operations, thus reasonably assuring that the WHP TennCare members received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether WHP met certain contractual obligations under the CRA and whether WHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;
- Determine whether WHP had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its members on an ongoing basis;
- Determine whether WHP properly adjudicated claims from service providers and made payments to providers in a timely manner;
- Determine whether WHP had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and
- Determine whether WHP had corrected deficiencies outlined in prior examinations of WHP conducted by TDCI.

**III. PROFILE**

A. Administrative Organization

Victory Health Plan, Inc. (VHP), formerly Vanderbilt Healths Plan, Inc., was incorporated in the State of Tennessee on May 14, 1993, for the purpose of providing managed health care services to individuals, including those participating in the State's TennCare Program. On February 21, 2005, VHP requested a modification to its Certificate of Authority (COA) to reflect the new corporate name Windsor Health Plan of TN, Inc. (WHP). On February 24, 2005, TDCI granted this modification with an effective date of February 18, 2005. WHP is a wholly owned subsidiary of Windsor Health Group, Inc. (Windsor). The plan name VHP Community Care is utilized by WHP for TennCare Operations.

The officers and board of directors for WHP at June 30, 2004, were as follows:

WHP Directors & Officers

Phillip Hertik, Chairman  
Michael Bailey, President & Chief Executive Officer  
Willis Jones, Executive Vice President & Secretary

B. Brief Overview

On September 3, 1993, TDCI issued WHP a certificate of authority to operate as an HMO. WHP has participated in the TennCare Program since its inception on January 1, 1994.

Effective July 1, 2002, the CRA with WHP was amended for WHP to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the Bureau of TennCare in restructuring the program design to better serve Tennesseans adequately and responsibly. WHP agreed not to make any change to the reimbursement rates, reimbursement policies and procedures, and medical management policies in effect on April 16, 2002, unless such changes received approval in advance by the Bureau of TennCare.

During the stabilization period, WHP receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to WHP. The TennCare Bureau reimburses WHP for the cost of providing covered services to TennCare enrollees. WHP contracts with the related party, Windsor Management Services, Inc. (WMS), formerly Victory Management Services, Inc., to provide management services.

WHP is currently authorized by TDCI and the TennCare Bureau to operate in the community service area of Davidson County, Tennessee. All premium revenue earned by WHP is from payments received for enrollees assigned by the TennCare Bureau. As of June 30, 2004, WHP reported enrollment of approximately 37,000 TennCare members.

C. Claims Processing Not Performed by WHP

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental

- Pharmacy
- Behavioral Health

During the period under examination, WHP contracted with Perot Systems, formerly Shared Medical Services (SMS), for the processing and payment of claims submitted by providers.

#### **IV. PREVIOUS EXAMINATION FINDINGS**

The previous examination findings are provided for informational purposes. The following were claims processing and financial deficiencies cited in the examination by the TDCI for the period January 1, 2000, through December 31, 2000:

##### **A. Claims Processing Deficiencies**

1. WHP did not process claims in accordance with the timeliness standards set forth in the TennCare contract and the Prompt Pay Act in January 2001.
2. All the encounter data elements reported on nine claims were not recorded completely and accurately in the claims processing system.
3. WHP did not send explanations of benefits to enrollees with deductible/coinsurance responsibility.
4. The benefit accumulator did not accurately accumulate two enrollees' out-of-pocket expenses.
5. The weekly claims processing report for April 20, 2001, did not include claims information regarding claims processed by WHP's pharmacy contractor. Also, no documentation was provided for the average turnaround time for adjudicated claims reported on the weekly claims processing report.
6. Claims received at the main office in Brentwood, Tennessee, were not date stamped and logged before WHP sent them to the claims processor in Oklahoma.

Finding number 6 above is repeated as part of this report.

##### **B. Financial Deficiencies**

1. Twenty-one outstanding checks were not properly written-off.
2. The review of the March 2001 medical loss ratio (MLR) report, which covered the period from July 1, 2000 through March 31, 2001, revealed several discrepancies.
3. The management fees for the period under examination were not calculated in accordance with the management contract in effect during the year.

Finding number 3 above is repeated as part of this report.

## **V. SUMMARY OF CURRENT FINDINGS**

The summary of current factual findings is set forth below. The details of testing as well as management's comment to each finding can be found in Sections VI, VII and VIII of this examination report.

### **A. Financial Deficiencies**

1. WHP did not amend the management agreement at July 1, 2002, to reflect the lowered administrative payments received from TennCare. WHP should amend the management agreement to WMS to reflect an amount equal to or less than the administrative payments received from the TennCare Bureau. (See Section VI.A.3.)
2. WHP should review its methodology for the apportionment of management fees to NAIC administrative expense and categories. WHP should allocate the WMS management fee to expense categories as if these costs had been borne by WHP itself. If specific identification is not possible, then allocation based on pertinent factors or ratios is acceptable. Documentation should be maintained to support the allocation methodology. Any change to the current methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expenses on the NAIC financial statements. (See Section VI.A.3.)
3. No interest was generated from the funds held on deposit for the State but WHP should continue to seek a financial institution to deposit provider payments that generates interest revenue. (See Section VI.A.5.)
4. WHP presentation of Report 2A for the period ended June 30, 2004, did not report any amount in the line items for copayments, subrogation, and coordination of benefits. The recoveries were incorrectly netted against other medical expense categories. The deficiency in preparing Report 2A will not affect WHP's reported net income or net worth at June 30, 2004. (See Section VI.B.)

### **B. Claims Processing Deficiencies**

1. The following deficiencies were noted in the claims payment accuracy report:
  - WHP incorrectly allowed all sampling and testing for the claims accuracy report to be performed by the subcontractor, Perot Systems. WHP should have performed these procedures as a monitoring tool to ensure the

accuracy of the claims processing subcontractor. The delegation of claims processing requirements of the CRA to a subcontractor does not terminate or reduce the responsibility of WHP to assure compliance with the CRA.

Subsequent to the examination period, WHP began performing the sampling and testing for the claims payment accuracy reports.

- WHP and Perot Systems did not correct one of the 13 incorrectly processed claims in the claims processing system.

(See Section VII.C.2.)

2. Review of mailroom and claims inventory control noted the following deficiencies:
  - Claims received at the Brentwood offices are not logged; therefore, no reconciliation can be performed to ensure that Perot Systems enters the forwarded claims into the claims processing system.
  - The received date for claims received at the offices of WHP is entered inconsistent.
  - WHP/Perot Systems should develop procedures to eliminate the differences discovered in the reconciliation of claims inventories.

(See Section VII.M.)

C. Compliance Deficiencies

1. As of examination fieldwork, the provider manual did not reflect changes to the TennCare program, i.e., dental and pharmacy benefits carve-outs. WHP should submit an updated provider manual to TDCI for approval. (Section VIII.B.)
2. Three provider agreements selected for testing did not contain all provisions required by Section 2-18. of the CRA. (See Section VIII.C.)
3. WHP failed to make four of twelve capitation payments tested to providers in a timely manner in accordance with the provider contract or Section 2.9.g.1. of the CRA. (See Section VIII.D.)
4. WHP's procedures to monitor the claims processing subcontractor were inadequate. The following deficiencies were noted in WHP's subcontractor monitoring procedures:
  - WHP incorrectly allowed all sampling and testing for the claims accuracy reports submitted to TDCI and the TennCare Bureau to be performed by Perot Systems.

- On-site visits to review Perot Systems operations have not been scheduled.

(See Section VIII.E.)

5. WHP should submit to TDCI as material modification to its Certificate of Authority a claims processing subcontract that reflects actual operations where WMS has subcontracted its responsibilities under the management agreement to Perot Systems with any necessary approval required by the TennCare Bureau. (See Section VIII.E.)
6. WHP lacked an internal audit function as part of WHP's organizational structure. (See Section VIII.H.)
7. WHP does not require periodic declaration by officers, directors, and key employees to ensure compliance with the conflict of interest policy or code of conduct. (See Section VIII.J.)

## VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

### A. Financial Analysis

As an HMO licensed in the State of Tennessee, WHP is required to file annual and quarterly financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if WHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2004, WHP reported \$4,565,214 in admitted assets, \$50,679 in liabilities, and \$4,514,535 in capital and surplus on its NAIC quarterly statement. WHP reported total net income of \$32,122 on its statement of revenue and expenses.

#### 1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires WHP to establish and maintain a minimum net worth equal to the greater of (1) \$1,500,000 or (2) an amount totaling 4% of the first \$150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of \$150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives

any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law adopted by amendment to the required Title XIX state plan.” Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

#### 2004 Statutory Net Worth Calculation

WHP’s premium revenue per documentation obtained from the TennCare Bureau totaled \$51,705,292 for the calendar year 2003; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), WHP’s minimum statutory net worth requirement was \$2,068,212. WHP reported total capital and surplus of \$4,514,535 as of June 30, 2004, which is \$2,446,323 in excess of the minimum worth requirement.

#### Premium Revenue for the Examination Period

For the examination period January 1 through June 30, 2004, the following is a summary of WHP’s premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from TennCare for the period January 1 through June 30, 2004	\$2,514,192
Reimbursement for premium tax payments from TennCare for the period January 1 through June 30, 2004	303,707
Reimbursement for medical payments from TennCare for the period January 1 through June 30, 2004	<u>27,456,092</u>
Total premium revenue for the period January 1 through June 30, 2004	<u>\$30,273,991</u>

#### 2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and (3) require all HMOs licensed in the state to maintain a deposit equal to \$900,000, plus an additional \$100,000 for each \$10 million or fraction thereof of annual premium revenue in excess of \$20 million and less than \$100 million as reported on the most recent annual financial statement filed with TDCI, plus \$50,000 for each \$10 million or fraction thereof of annual premium revenue in excess of \$100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue “any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted

by amendment to the required title XIX state plan.”

Based upon premium revenues for calendar year 2003 totaling \$51,705,292, WHP’s statutory deposit requirement at June 30, 2004, was \$1,300,000. WHP had on file with TDCI the necessary safekeeping receipts documenting that deposits totaling \$1,310,000 had been pledged for the protection of the enrollees in the State of Tennessee. Subsequently, an amendment to the CRA as of July 1, 2005, changed the deposit requirements to equal the calculated statutory net worth. WINDSOR increased the deposits pledged for the protection of the enrollees in the State of Tennessee to \$2,710,000 to comply with the CRA.

3. Management Agreement and Administrative Expense Allocations

WHP contracts WMS, formerly Victory Management Services, Inc., to provide management services. WMS is a wholly owned subsidiary of Windsor, the company that also wholly owns WHP. Prior to the “non-risk” period effective July 1, 2002, WHP’s management fee to WMS under the terms of its management agreement was essentially 11.5% of the monthly premiums received by WHP from TennCare with adjustments for interest due to Vanderbilt Health Services, Inc. for a surplus note. As previously mentioned, during the “non-risk” period effective July 1, 2002, VHP received from the TennCare Bureau a fixed administrative fees based upon the number of TennCare enrollees assigned to VHP. This fixed administrative payment is less than the 11.5% implied revenue that VHP continued to pay WMS after July 1, 2002. WHP did not amend the management agreement at July 1, 2002 to reflect the lowered administrative payments received from TennCare. Because of the disparity between administrative fee payments received from the Bureau and the payment to WMS based of the 11.5% implied revenue in the management agreement to a related party, VHP began incurring significant losses and a substantial decrease in net worth as demonstrated in the following table:

Capital and Surplus Amounts Reported on the NAIC Financial Statements	
As of June 30, 2002	\$6,506,350
As of June 30, 2003	4,579,617
Decrease in Net Worth	\$1,926,733

On February 11, 2004, WMS forgave WHP any further obligation to WMS in excess of the actual administrative fees received by WHP for the period July 1, 2003, through December 31, 2003, but no forgiveness was made for the period July 1, 2002 through June 30, 2003. WHP has received similar forgiveness of the difference between the contracted management fee and the actual administration fees paid by the TennCare Bureau for the calendar year 2004. WHP should amend the management agreement to WMS to reflect an amount equal to or less than the administrative fees received from the TennCare Bureau.

### Management's Comment

The management agreement between WHP and WMS was written, approved, and implemented at a time when the TennCare program was operated on a risk-bearing model. The management fees provided for under the agreement were reasonable given the operating environment. Since the implementation of the management agreement, the State changed the program to the ASO model, and thereby unilaterally reduced the funds available for payment of management fees by WHP to WMS. In response to the implementation of the ASO model, WMS has periodically forgiven the unpaid management fees. This process has not adversely affected WHP. Given that the State has announced its intention to return TennCare to a risk-bearing model, WHP believes that the existing contract remains appropriate and reasonable under the circumstances.

For NAIC financial statement reporting purposes, the management fee must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC's Statements of Statutory Accounting Principles (SAP) No. 70 requires that expenses under a management contract shall be apportioned to the entities incurring the expense as if the expense has been paid solely by the incurring entity. SAP 70 requires that these expenses be further allocated to three general categories – claims adjustment expense, general administrative expense, and investment expense. Allocation to these categories "should be based on a method that yields the most accurate results." Specific identification of an expense with an activity that is represented by one of the categories will generally be the most accurate method. Where specific identification is not feasible allocation of expense should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis.

For allocating the management fee paid by WMS to WHP to expense classifications on the NAIC financial statements, WHP used percentages derived from the administrative general ledger accounts of WMS and applied the WMS percentages on a pro-rata basis to WHP administrative expense categories. This allocation method is inconsistent with SSAP 70 requirement set forth above. Since WMS provides administrative services to other organizations other than WHP, the cost directly incurred for each organization administered by WMS must be specifically identified. Examples of costs which can be specifically identified would include salaries and compensation to employees devoted 100% to WHP. After specific identification, allocation of the remaining shared expenses should be allocated based on pertinent factors or ratios.

WHP should review its methodology for the apportionment of management fees to NAIC administrative expense categories. WHP should allocate the WMS management fee to expense categories as if these costs had been borne by WHP itself. If specific identification is not possible, then allocation based on

pertinent factors or ratios is acceptable. Documentation should be maintained to support the allocation methodology. Any change to the current methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expenses on the NAIC financial statements.

#### Management Comments

WHP believes that the previous methodology utilized for apportioning management fees provided results that were accurate, as to WHP, in all material respects, but WHP will apply the NAIC methodology in the future.

#### 4. Claims Payable

As of June 30, 2004, WHP reported no claims unpaid on the NAIC quarterly statement. This amount represented an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending June 30, 2002. Review of triangle lag payment report after June 30, 2004, for dates of service before July 1, 2002, determined that the reported claims payable appears reasonable.

#### 5. Interest Earned on State Funds

Section 3-10.h.2.(d) of the CRA states that interest generated from deposit of funds held for provider payments shall be the property of the State. Additionally the management agreement between WHP and WMS, requires WMS to deposit all funds it receives on behalf of WHP in interest-bearing federally-insured accounts established in WHP's name. These funds represent the outstanding checks to medical providers. WHP has not deposited these funds into an interest bearing account, therefore no interest was returned to the State. WHP indicated WHP was unable to engage a financial institution that would provide interest because of the low average balance of outstanding checks. No interest was generated from the funds held on deposit for the State but WHP should continue to seek a financial institution to deposit provider payments that generates interest revenue.

#### Management's Comments

WMS, on behalf of WHP continues to seek a financial institution that will pay interest on deposits held for provider payments.

#### 6. Recovery Amounts/Third Party Liability

Section 3-10.h.2(f) and (g) of the CRA states that third party liability recoveries and subrogation amounts related to the non-risk agreement period should be deducted from medical reimbursement requests to the TennCare Bureau. WHP reduced medical reimbursement requests to the TennCare Bureau for the amounts recovered from third party liabilities and subrogation.

B. Administrative Services Only (ASO)

As previously mentioned, effective July 1, 2002, WHP's CRA was amended so that WHP would operate at no financial risk for the cost of medical claims until December 31, 2003. The stabilization period has since been extended to at least December 31, 2006.

These types of arrangements are considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for an ASO line of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for WHP for dates of service after June 30, 2002.

The CRA requires a deviation from ASO reporting guidelines. The required submission of the supplemental TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if WHP were still operating at risk. Section 2-10.i. of the CRA requires WHP is to provide "an income statement addressing the TennCare operations." WHP provided this on the Supplemental TennCare Operations Statement, Report 2A.

The following deficiency was noted in WHP's presentation of Report 2A for the period ended June 30, 2004: no amounts were reported in the line items for copayments, subrogation, and coordination of benefits. The recoveries were incorrectly netted against other medical expense categories. The deficiency in preparing Report 2A will not affect WHP's reported net income or net worth at June 30, 2004.

Management's Comments

WHP previously had global capitation arrangements with two large provider groups, which meant that the majority of WHP's provider claims were not processed as fee-for-service claims. As a result, the information required to provide line item detail for copayments, subrogation and coordination of benefits was not available for reporting purposes. The capitation arrangements have since ended, and WHP will report copayments, subrogation, and coordination of benefits on Report 2A as requested.

C. Medical Fund Target

Effective July 1, 2002, the CRA requires WHP to submit a Medical Fund Target (MFT) on a monthly basis. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for IBNR claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. WHP submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for expenses incurred but not reported have been reviewed for accuracy. No discrepancies were noted during the review of documentation supporting the amounts reported on the MFT report.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no examination adjustments to capital and surplus.

**VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM**

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether WHP pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), and Section 2-18. of the CRA. The statute mandates the following prompt pay requirements:

The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.

(A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for

denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI had previously requested data files from all TennCare MCOs containing all medical claims processed during the months of January 2004, April 2004, and July 2004. The dates of services of claims processed during these three months are of the most relevance to the examination period. Each set of data was tested in its entirety for compliance with the prompt pay requirements of Tenn. Code Ann. Because these tests were performed on all claims processed in January 2004, April 2004, and July 2004, no projections to the population are needed. Listed below are the results of these analyses:

**Medical Results**

	<b>Within 30 days</b>	<b>Within 60 days</b>	<b>Compliance</b>
T.C.A. Requirement	90%	99.5%	
January 2004	98%	100.0%	<b>Yes</b>
April 2004	99%	100.0%	<b>Yes</b>
July 2004	100%	100.0%	<b>Yes</b>

WHP processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements in the months of January 2004, April 2004, and July 2004.

**B. Determination of the Extent of Test Work of the Claims Processing System**

Several factors were considered in the determination of the extent of testing performed on WHP's claims processing system.

The following items were reviewed to determine the risk that WHP had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or Independent Reviews on file with TDCI related to accurate claims processing
- Adequacy of WHP's monitoring procedures for subcontractors
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy report
- Review of internal controls

As noted below, TDCI and the Comptroller discovered deficiencies related to WHP's procedures for preparing the claims payment accuracy reports, mailroom and inventory controls, the adequacy of WHP's monitoring procedures for the claims processing subcontractor, Perot Systems. However, the deficiencies did not result in an increase in TDCI's and Comptroller's substantive testing.

C. Claims Payment Accuracy Report

Section 2-9. of the CRA requires that 97% of claims be paid accurately upon initial submission. WHP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

WHP reported the following results for the year ended December 31, 2004:

	<b>Results Reported</b>	<b>Compliance</b>
First Quarter 2004	99.89%	<b>Yes</b>
Second Quarter 2004	99.75%	<b>Yes</b>

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims payment accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter 2004 claims payment accuracy report. This review included verification that the number of claims tested by the MCO constituted an adequate sample to represent the population. TDCI and the Comptroller judgmentally selected for testing 20 correctly processed claims to verify WHP's testing accuracy. Also, 13 incorrectly processed claims were selected for review to ensure the errors had been corrected.

2. Results of Review of the Claims Payment Accuracy Reporting

The following deficiencies were noted in the claims payment accuracy report:

- WHP incorrectly allowed all sampling and testing for the claims accuracy report to be performed by the subcontractor, Perot Systems. WHP should have performed these procedures as a monitoring tool to ensure the accuracy of the claims processing subcontractor. The delegation of claims processing requirements of the CRA to a subcontractor does not terminate or reduce the responsibility of WHP to assure compliance with the CRA.

Subsequent to the examination period, WHP began performing the sampling and testing for the claims payment accuracy reports.

- WHP and Perot Systems did not correct one of the 13 incorrectly processed claims in the claims processing system.

#### Management's Comments

Prior to the 2004 audit, WHP had implemented certain systems and policies to assure accuracy in claims payment and processing, including: (i) a daily pre-check claim audit to ensure appropriate adjudication and pricing of claims processed the previous day; (ii) a daily review of the Hold Report to ensure that all pending claims are processed in compliance with CRA timeliness requirements; (iii) all claims greater than \$3,000 are submitted for audit by a senior claims auditor; (iv) all claims greater than \$7,500 are submitted for audit by the Director of Reimbursement and Administration; (v) all claims greater than \$25,000 are submitted for review by the Chief Financial Officer; and (vi) all checks greater than \$100,000 require a second signature by the Chief Financial Officer or the Chief Executive Officer. Furthermore, the Perot Systems audit department at its Plano, Texas location audited 3% of each weekly check run to monitor clerical and financial accuracy in accordance with the CRA. These systems and policies remain in place and have been effective at promoting timely and accurate claims payment and processing.

Beginning in the third quarter of 2004, WHP began to conduct a Quarterly Claims Accuracy audit from its Brentwood office. A random sample of 300 claims is requested and reviewed for clerical and financial accuracy by an internal auditor. These results are used to report to the State in order to assure compliance with the CRA. In addition, WHP continues to monitor the Perot weekly post-check run audit in order to address promptly any financial or clerical issues that may be discovered through the audit process.

#### D. Claims Selected For Testing

Sixty additional claims were selected from the April 2004 prompt pay data files previously submitted to TDCI. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance within the total population of claims by WHP.

To ensure that the April 2004 data file included all claims processed in the month, the total amount paid per each of the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Attachment XII of the CRA lists the minimum required data elements to be captured from medical claims and reported to TennCare as encounter data. Original hard copy claims were requested for the 60 claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into WHP's claims processing system. No discrepancies were noted between the information submitted on the claims and the data recorded in WHP's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. For the 60 claims selected for testing, no discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. For the 60 claims selected for testing, no discrepancies were noted.

H. Copayment Testing

The purpose of testing copayments is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated in accordance with section 2-3.i. of the CRA.

Five enrollees were selected from the top 100 copay list provided by WHP and their year-to-date claim history was reviewed. The claims processing system does not contain complete copayment information. However, VHP daily combines the copayments from the claims processing system with the pharmacy and behavioral health organization (BHO) copayments into its data warehouse for monthly review to determine if enrollees have exceeded the out-of-pocket limits.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The remittance advices for 10 of the 60 claims selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by WHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for five claims previously selected for testing. The check amounts agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended and Unpaid Claims

The purpose of analyzing pended and unpaid claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

WHP provided the examiners a pended and unpaid claims report as of September 23, 2004. WHP reported a total of 2,623 pended and unpaid claims of which 34 claims were over 60 days old. The review of the 34 claims indicated refunds of overpayments were due from the providers. No material unrecorded liability exists for claims exceeding 60 days.

L. Electronic Claims Capability

Section 2-9.g. of the CRA states, "The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment. . . ." The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until

October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

Perot Systems has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom Testing and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures followed by WHP ensure that all claims received from providers are either returned to providers where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with mailroom and claims processing personnel.

TDCI and the Comptroller review of mailroom and claims inventory control noted the following deficiencies:

- The claims received at the home office of WHP in Brentwood, Tennessee, are not logged before the claims are forwarded to Perot Systems in Tulsa, Oklahoma, for entry into the claims processing. Without a log of claims received at the offices of WHP, no reconciliation can be performed to ensure that Perot Systems enters the forwarded claims into the claims processing system.
- Five claims were judgmentally selected from a batch of incoming mail on September 27, 2004, at the offices of WHP in Brentwood (the billing instructions in the provider manual require providers to submit claims to a post office box in Tulsa). Subsequently, the received date entered into the claims processing system for these five claims was compared to September 27, 2004. One claim was entered into the system with a received date of September 27, 2004. Four of the claims were entered into the claims processing system with the received date of October 5, 2004, for a difference of eight calendar days. The testing reveals that the received date entered for claims received at the offices of WHP is inconsistent.
- Perot System prepares reports which compare inventory and claims counts on a weekly basis. The reports for the weeks ending March 22, 2004, March 29, 2004, October 11, 2004, October 18, 2004, and October 25, 2004 were provided for review. Each weekly report indicates a difference between the physical claims counts on Mondays as reconciled to the previous Monday physical count plus adjustments for receipts and reductions during the week. The average difference for the five reports reviewed was 13.2 unexplained claims. WHP/Perot Systems should develop procedures to eliminate the differences in reconciliation of claims inventories.

Management's Comments

As noted in the response above under Section VII.C.2, prior to the 2004 audit, WHP had implemented certain systems and policies to assure accuracy in claims payment and processing. These systems and policies remain in place and have been effective at promoting timely and accurate claims payment and processing.

In addition, beginning in the first quarter of 2005, Perot Systems completed the process of moving their mail room services for WHP from the Tulsa, OK office to the Plano, TX office. This move provided WHP with the benefits of claim imaging, better reconciliation and OCR technology. The Plano office operates on a clean claim basis each day. All claims received on any particular day are sorted, batched and scanned, and the OCR process is begun. Within an average of 3 days, each claim is converted into an electronic claim, returned to the mailroom for manual keying or returned to the provider. WMS conducted an onsite review of this process which occurred in November 2005. A random day was selected for verification of complete claim entry or status and all claims were accounted for.

WMS's Brentwood, TN office has also implemented steps to ensure that all claims sent from Brentwood to Plano, TX for processing are first entered in Brentwood by WMS. Each batch is counted and a header sheet attached for verification of receipt from the Plano, TX mailroom. Large batches are scanned prior to being forwarded, and are retained on the WMS Brentwood server for follow up if needed.

## **VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING**

### **A. Provider Complaints**

The purpose for testing provider complaints is to determine if WHP has developed adequate procedures to ensure that providers receive a timely response. The written policies and procedures concerning provider complaints were reviewed. Six provider complaints were selected for testing. WHP responded to each of the complaints within 30 days.

### **B. Provider Manual**

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

WHP's provider manual was last approved on September 25, 2002. As of examination fieldwork, the provider manual did not reflect changes to the TennCare program, i.e., dental and pharmacy benefits carve-outs. WHP should submit an updated provider manual to TDCI for approval.

### **Management's Comments**

WHP is revising its provider manual and will submit a revised Manual to TDCI no later than June 30, 2006.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. The minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between WHP and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by WHP shall at a minimum meet the current requirements listed in Section 2-18.

Three provider agreements related to claims selected for testing were reviewed to determine if they contained all the minimum language requirements of Section 2-18. of the CRA. A physician group contract, a home health care provider contract, and a hospital/physician medical group contract were selected for review.

The following language requirements of Section 2-18. of the CRA as amended on July 1, 2003, were not amended in each of the three contracts tested:

- ll. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules, subsequent amendments, or any and all Court Orders. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.
- rr. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

The following language requirements of Section 2-18. of the CRA as amended on July 1, 2002, were not amended in the hospital/physician medical group contract:

- ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency

claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).

- nn. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. A listing of the EPSDT benefit package is contained in Attachment IX of this Agreement. All provider agreements must contain language that references the EPSDT benefit package found in Attachment IX and the agreement shall either physically incorporate Attachment IX or include language to require that the attachment be furnished to the provider upon request. At the next renewal or amendment period of provider agreements, this Attachment IX shall be deleted and replaced by the new reference and items found in Sections 2-3.u.8 of this Agreement;

#### Management's Comment

WHP believes that its current contract templates contain all required provisions. In order to bring all existing contracts in compliance with the CRA requirements, WHP has drafted a Compliance Amendment to be distributed to all providers. WHP will submit the Compliance Amendment to the TennCare Division, Department of Commerce and Insurance, for approval prior to distribution. The WHP Network Development staff anticipates that the process of submission for approval and distribution to all providers will be completed by June 30, 2006.

#### D. Provider Payments

Examiners tested twelve capitation payments to providers to determine if WHP had complied with the payment provisions set forth in its provider agreements. If the provider contract does not specify the date the provider is to be paid, then Section 2-9.g.1. of the CRA requires the monthly payment to be issued by the tenth day of the calendar month.

WHP failed to make four of twelve capitation payments tested to providers in a timely manner in accordance with the provider contract or Section 2.9.g.1. of the CRA.

#### Management's Comments

WHP entered into its capitated provider arrangements prior to the State of Tennessee's implementation of the ASO model for TennCare. The additional steps required by the ASO funding request process often caused delays of a week or more prior to WHP being able to release payments to providers, which made it impossible to meet the original contract deadlines. WHP consistently paid its capitated providers as soon as the funds were available. WHP's providers were kept informed of the status and understood that it was not possible to make the capitation

payments on the time schedule provided under the original contracts.

E. Subcontracts

In support for the examination request for the current claims processing subcontract, WHP provided an unsigned agreement between WHP and Shared Medical Services. During 1999, this agreement was submitted to TDCI as a material modification to WHP's Certificate of Authority. Before the examination period, Shared Medical Services was purchased by Perot Systems. WMS, WHP's management company, actually pays Perot for claims processing services.

WHP's approved management agreement with WMS states that WMS will "design, implement, and maintain, in accordance with generally recognized standards in the managed care industry for the management of HMOs, and as may be appropriate for a TennCare MCO, systems and procedures for. . . claims administration. . . ." Delegation of the claims administration to Perot Systems does not reflect the organizational documents previously submitted to TDCI for prior approval.

Obtaining claims processing services through a contract between WMS and Perot/Shared Medical Services is in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operation documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

WHP should submit to TDCI as material modification to its Certificate of Authority a claims processing subcontract that reflects actual operations where WMS has subcontracted its responsibilities under the management agreement to Perot Systems with any necessary approval required by the TennCare Bureau.

Management's Comments

WMS has consistently fulfilled its obligations under the management agreement, and has actively managed the design, implementation and maintenance of claims processing and administration systems appropriate for WHP's managed care operations. WMS has utilized outside vendors to assist with the performance of specific aspects of the claims processing systems, but WMS has retained both the ultimate responsibility for the performance of the contracted functions and the associated financial risks of performance.

WHP believes that obtaining specified claims input and processing services through Perot Systems, the successor in interest to the Shared Medical Services operations, is consistent with the information submitted to TDCI when WHP obtained its certificate of authority.

### Rebuttal

TDCI will request as part of a corrective action plan that WHP file a material modification to its Certificate of Authority to correctly reflect the subcontract relationship with Perot for claims processing.

Additionally TDCI reviewed WHP procedures to monitor Perot Systems. WHP's procedures to monitor the claims processing subcontractor were inadequate. The following deficiencies were noted in WHP's subcontractor monitoring procedures:

- As mentioned above, WHP incorrectly allowed all sampling and testing for the claims accuracy reports submitted to TDCI and the TennCare Bureau to be performed by Perot Systems. WHP should have performed these procedures as a monitoring tool to ensure the accuracy of the claims processing subcontractor. The delegation of claims processing requirements of the CRA to a subcontractor does not terminate or reduce the responsibility of WHP to assure compliance with the CRA. Subsequent to the examination period, WHP began performing the sampling and testing for the claims payment accuracy reports.
- Interviews with WHP personnel indicated that on-site visits to review Perot Systems operations have not been scheduled. As noted above, TDCI and Comptroller found deficiencies in the claims inventory reconciliation procedures at Perot.

### F. Non-discrimination

Section 2-24 of the CRA requires WINDSOR to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various WHP staff and a review of policies and related supporting documentation, WINDSOR was in compliance with the reporting requirements of Section 2-24 of the CRA.

### G. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner...." WHP has complied with this statute.

### H. Internal Audit Function

The importance of an internal audit function is to provide an independent review and

evaluation of the accuracy of financial record keeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

During the examination of WHP, it was noted that WHP lacks an internal audit function as part of WHP's organizational structure. As previously noted, WHP received TennCare premium revenues of \$51,705,292 for the calendar year 2003 and \$30,273,991 for the period January 1 through June 30, 2004. The significant amount of premiums received would warrant the employment of at least one internal auditor by WHP. Also, the examination has discovered deficiencies which possibly could have been avoided with a properly functioning internal audit department, i.e., claims inventory reconciliation procedures by Perot Systems. Per Section 2-9.a.14. of the CRA effective July 1, 2005, WHP is required to have in place an internal audit function and Section 2-9.g. requires that internal audit should be performing the claims payment accuracy testing beginning with the Third Quarter 2005 reporting due on October 30, 2005. Additionally since WINDSOR does not have an Internal Audit Department, focused reviews of compliance with the TennCare CRA including the determination of compliance with conflict of interest have not been performed.

#### Management's Comments

WHP, through WMS, conducts internal audit functions, although it does not have a separately designated internal auditor. Also, as noted in the response above under Section VII.C.2, WHP has implemented certain systems and policies to assure accuracy in claims payment and processing. In addition, WMS has a Compliance Officer who is tasked with general oversight of compliance issues, a Government Programs department that is tasked with assuring compliance with governmental contracts, and an Operational Performance Committee that reviews operational and financial matters related to financial performance, operation standards, claims "outliers", medical utilization, provider contracting, and other matters pertinent to compliance with WHP's obligations under the CRA. WHP will continue to monitor the performance of its existing internal audit process to assure compliance with CRA requirements. If necessary, WHP will denote individuals that currently perform internal audit functions accordingly.

#### Rebuttal

WHP should ensure compliance with CRA Section 2.9.c.13. which states, "The CONTRACTOR shall appoint specific staff to an internal audit department which shall report directly to the board of directors or other such appropriate level of management."

I. Stabilization

Section 3-10.h.2(a). of Amendment 3 of WHP's CRA requires WHP to comply with the following:

The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002 for covered services as defined in Section 3-10.2.(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

WHP's management has confirmed compliance with the stabilization requirements. During testing of financial, claims processing, and provider contracts, no deviations to the stabilization requirements were noted by TDCI and the Comptroller.

J. Conflict of Interest

Section 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to WHP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

As of examination fieldwork ending November 2, 2004, WHP indicated that Human Resource policies address conduct and expectations of employees. However, WHP does not require periodic declaration by officers, directors, and key employees to ensure compliance with the conflict of interest policy or code of conduct.

Management's Comment

WHP now requires its officers, directors and key employees to certify compliance with (i) the CRA requirements regarding conflicts of interest and lobbying and (ii) the corporate code of conduct,

Subsequent to the examination period, conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflict of interest and lobbying. Failure to comply with the provisions required by the CRA shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for

including the substance of the conflict of interest clause of the CRA in all agreements, subcontracts, provider agreements, and any and all agreements that result from the CRA.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of WHP.